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ABSTRACT

The role of family therapy in a clinic for developmentally delayed preschoolers is examined. Two types of families are said to benefit from the family therapy approach: families in which the child's needs are misunderstood or somehow misread, and families whose dysfunctional transactional patterns antedated the child's problems. Initial screening and assessment sessions are described, as are approaches to "seducing" the family into therapy. Collaboration with other therapists, and sophistication about child development, are explained to be requirements of the family therapist. (CL)

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A FAMILY-ORIENTED APPROACH TO THE TREATMENT OF DEVELOPMENTALLY-DELAYED PRESCHOOLERS.

By

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Parents are turning increasingly to developmental clinics when they find that their child is delayed in learning how to walk or talk or acquire other age-appropriate skills. Authors such as Poznanski (1978) have emphasized how crucial the family is in determining how well or how poorly the child responds to the developmental therapy that it subsequently receives. Despite this, many such clinics tend not to routinely consider family interventions when planning treatment. Traditionally, the exclusive emphasis is on individual treatment of the child such as physiotherapy or speech therapy.

In our own clinic for developmentally-delayed preschoolers, we have attempted to evolve a more family-based approach to treating such problems. Family assessment and family therapy are fully integrated into the process of treatment planning and service delivery. In the time that is left, I would like to discuss what kinds of families in such a setting can potentially benefit from family therapy, how we in the clinic go about assessing the family's functioning and how we attempt to "sell" family therapy to those who are felt to need it. I hope to give an indication as well of the dual role that family therapy can play in such a clinic: First, as a form of direct treatment. Second, and equally important, as an epistemological system which encourages <u>all</u> treating professionals to see the family as a whole as their client and to think of their <u>own</u> interventions in strategic terms.

The past few years have seen an increasing acceptance of the interactional model of child development (Thomas, 1981). Such a model has particular relevance when applied to children with developmental problems. Because of these children's special needs, the process of parenting them can often be quite stressful (Doernberg, 1978). However, it is important to look not only at how the child's needs are affecting

family life but also at how the family's functioning as a system is affecting the child's developmental progress. While it is often the child's handicaps and particular requirements that can lead to family difficulties, the opposite can be true as well: The child's poor response to treatment can be symptomatic of more generalized family dysfunction. When this is found to be the case, family therapy can play a major role in the overall treatment package.

Broadly speaking, there appear to be two classes of families in such a setting that may require family therapy: The first consists of those families whose difficulties are directly related to their strategies for coping with having a developmentally delayed child. The second is made up of families whose transactional difficulties antedate their discovery of their child's problems.

The first group is characterized by families in which the child's needs are misunderstood or somehow misread. In trying to help the child as best they can, these families develop strategies which are ultimately counterproductive in nature. Through the process of denial the can develop unrealistically high expectations of the child. Or, at the other extreme, they can overprotect the child to the extent that it has little opportunity to function up to its potential. In either case, the child's overall development is ultimately compromised as it strives to meet these unrealistic standards. All this can become a systemic problem when every family member is assigned a role to play in this scenario. The needs of the other siblings are ignored and the marital relationship suffers as

everyone is recruited into the full-time job of "helping" Junior. In families such as these, the "solution" is clearly the problem. Once these roles become solidly entrenched, a straight advice-giving approach is often not enough to alter what are in effect structural changes in the family.

The other type of family that was mentioned was the one where transactional patterns were dysfunctional long before the parents discovered that their child had problems. In such families, the child's difficulties can come to serce an important function in the family. While the parents profess to desire to do all they can for their child, their behaviour indicates a need for it not to get too well too quickly.

A rather common example of this is the family where the child's problems function as a distancing mechanism between the spouses: Mother acquires a full-time job as the child's auxilliary therapist, taking him from treatment to treatment and filling his spare hours with various sorts of home programming. Father, deferring to Mother's superior "expertise" allows himself to be excluded from any significant relationship with the child. Usually he is quite content to develop his own outside interests while Mother works to make sure that the child does not become <u>too</u> competent or autonomous and so put her out of a job. When Father starts drifting too far out of the family, Mother will have a crisis claiming that she is overwhelmed by her responsibilities which she must shoulder with

no help from her husband. However, if Father should make the mistake of trying to become increasingly involved with the child, Mother sets to work to subtly undermine his authority and so restart the cycle.

These two types of families represent two extremes on the same continuum. Most "problem" families tend to fall somewhere in between. But not all families of developmentally-delayed children require family therapy. In the experience of our clinic only a minority, perhaps one third, do. In order to determine which cases do require such help, a family assessment is performed before the child has its developmental evaluations. The primary purpose of this interview is to try to develop a picture of how the family functions as a system so as to plan treatment accordingly.

All family members are required to attend the initial screening which is held in front of a one-way mirror. A developmental therapist observes from behind the mirror doing a preliminary "eye-balling" of the child in order to judge its appropriateness for the programme. This frees up the interviewer, usually a social worker, to concentrate on assessing the family's functioning as a unit. Through the use of a semi-structured interview format, the focus of the inquiry shifts from the child and its problems to questions relating to the siblings and the couple sub-systems. By the end of the interview, it is usually possible

to have a fairly clear idea of how the family has changed to accomodate the child and its perceived needs as well as how the child has accomodated to the family's needs.

At the end of this interview recommendations are made for further evaluations of the child's functioning by the physiotherapist, speech therapist or others. These assessments provide an additional opportunity to observe parent/child interaction as well as to obtain more detailed information on the day-to-day functioning of the child in the home.

Onces these assessments have been completed, an interdisciplinary case conference is held. The goal os such a conference is twofold: First, there is the sharing of findings and information among team members. Second and most important, an atiempt is made to develop a working hypothesis which can bridge the findings of the individual evaluations of the child to the data obtained during the family assessment. Such a hypothesis must be able, as much as possible, to explain the following:

1. Why has the problem developed?
2. How is it currently being maintained?
3. What ramifications is it having on family functioning?
4. Why was the child brought in at <u>this</u> time?

The nature of the hypothesis can varywidely depending on the individual child and family. It can range from an hypothesis of a clearly organically-based deficit in a child whose family's only needs are for occupational therapy to one in which the child is judged to have <u>no</u> problems of a developmental nature but who is living in a clearly

dysfunctional family.

The hypothesis should not only work to help explain the nature and the context of the presenting problem, but also must lead to a strategy for intervention. Decisions must be made concerning which services, including family therapy, should be provided. There is also a need for a strategy as to how the presenting complaint can be reframed to the family so as to get them to accept our recommendations for treatment. This is particularly crucial when family therapy is indicated.

Parents tend to come to a developmental clinic with a fairly specific shopping list. This is usually along the lines of: "Our Johnny doesn't talk---you fix him so he can". To respond to such a request with: "Well, what you all really need is family therapy" is often too much cognitive dissonance for the family to take and they may very well take their shopping list elsewhere.

What we have found to be a more successful approach is to, in a sense, "seduce" the family (Viaro, 1980) into treatment. In our experience, we have found that parents are most likely to accept a recommendation for family therapy when four conditions are met: First, the nature of the presenting complaint is reframed while still keeping its focus on the identified patient. Second, a logical link must be made between the referral complaint and the recommendation for family treatment. Third, there must be no suggestion of blaming the parents when family therapy is recommended. Fourth, family therapy itself is

reframed as being a way for parents to become involved as treatment partners.

To give an example, it does no good to say: "Junior's stammering is a serious problem and we've also noticed that you and your husband don't get along too well either". Instead, the problem would be put like this: "Junior's stammering seems to get worse when he's nervous (the parents have already used this word to describe the child's reaction to the parents' quarrels). We'd like to help him speak more clearly by giving him speech therapy here, but we can't really help him without your help. Since you're the people who are with Junior all day, you're in the best position to help make him less nervous. So we'd like to work with your family to help him with this problem. We really don't think his talking will get better unless we all work together on this".

Once the family has accepted this recommendation, the actual process of family therapy is not all that different than it would be in any other treatment setting. However, family therapy where a developmentally-delayed child is the identified patient does present its own unique challenges. In most cases, the therapist must accept the fact that he or she alone cannot "cure" the problem. Often the goal is a more limited but equally important one---helping the family to help the child achieve its maximum potential while at the same time not sacrificing the developmental needs of other family members to this end.

In order to help the family to work to this goal, two things are required of the family therapist: 1) a degree of relative sophistication about child development and 2) an ability to work collaboratively with professionals from other disciplines.

The family therapist must know enough about developmental sequences to be able to help the parents acquire realistic expectations of their child. The dictum that "you can't run until you can walk" takes on special meaning in this context.

I also mentioned the importance of collaboration with other treating professionals: The family therapist must be aware of the goals that these people are working on so that the messages that the family receives from different quarters are not contradictory in nature.

This doesn't mean that the family therapist should think of himself as an auxilliary occupational therapist. His job is not to make sure, for example, that all home programming is followed to the letter. Rather it is to explore how the responsibility for carrying it out is assigned: Does an ineffectual father assign the job to an elder sibling? Does the mother sabotage father's efforts to help out? In this sense, home programming can be seen as any other family task in family therapy: The family's response to the assignment provides important information regarding how the system and its various subsystems work.

Collaboration, of course, is a two-way street. Other therapists should be willing to learn from the family therapist. They need to be open to developing an understanding of how family systems function and to acquire the capacity to think of their own interventions in strategic terms...and be willing to modify their own approaches accordingly. In some cases this involves inviting father to participate in treatment sessions even if he is not as "skilled" as his wife in handling the child.

At other times it can mean acting less competent and efficient so that the parents can feel better about their own parenting skills. When collaboration develops to a certain point of mutual trust, it even becomes possible to have a co-therapy situation. For example, the family can be seen for treatment with both the family and the speech therapists present.

In essence what I am talking about is the process of accomodation and assimilation between the family therapist and other treating professionals. The ultimate product of such a process can be a more effective team system. While roles do not become interchangeable, team members do develop the capacty to derive the most benefit from each other's skills. When such a situation develops, the goals of the family therapist can become fully integrated into the treatment process.

REFERENCES

DOERNBERG, N.L. (1978). Some negative effects on family integration of health and educational services for young handicapped children. Rehabilitation literature, 39(4). 107-110.

POZNANSKI, E.O. (1978). Emotional issues in raising handcapped children. Rehabilitation literature, 34(11). 322-326.

THOMAS, A. (1981). Current trends in developmental theory. American journal of orthopsychiatry, 51(4). 580-609.

VIARO, M. (1980). Case report: smuggling family therapy through. Family process, 19(1). 35-44.